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IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

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REPLY BRIEF FOR PETITIONER HOSPITAL ASSOCIATION OF NEW YORK STATE

Our opening brief demonstrated that states, in regulating the provision of health care, have commonly recognized that not all payers' rates need be the same,

resulting in a shifting of hospital costs among different categories of payers. The State of New York has provided, for example, that the rates for in-hospital care must reflect the costs of providing care to patients unable to pay. The State has likewise provided that the rates charged to Medicaid patients should be lower than the rates charged to patients covered by commercial insurance or by self-insured funds. Not only are such regulations not considered to be at odds with federal law, but Congress, both before and after passage of the Employee Retirement Income Security Act of 1974 ("ERISA"), has acknowledged and approved of those arrangements. Indeed, Congress has specifically reviewed and approved the NYPHRM system at issue in this case. HANYS Br. 29-33.[1] Respondents have not challenged these propositions.

If these regulations of hospital costs are valid under ERISA—as respondents appear to concede that they are —it is hard to understand why the setting of lower rates for Blue Cross patients is, alone, invalid. The reason offered by respondents is that the different treatment of Blue Cross patients affects the "choices" made by ERISA plans because they might elect to subscribe to Blue Cross and thus benefit from the lower rates. But, as we have previously noted, it seems unlikely that Congress, by the general preemption provision in ERISA, meant to foreclose to ERISA plans an option enjoyed by all other purchasers of health care services in New York. HANYS Br. 34-35.

Moreover, the argument advanced by respondents is, ultimately, hollow. The State for many years has subjected Blue Cross to obligations not imposed on other payers (like commercial insurers and health maintenance organizations "HMOs")—obligations that, by increasing

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[1] "HANYS Br." refers to the Brief for Petitioner Hospital Association of New York State (HANYS). Unless otherwise indicated, "Respondents' Brief" or "Resp. Br." refers to the Brief for Respondents The Travelers Insurance Company, *et al.*

the costs of Blue Cross, or decreasing the costs of its competitors, would presumably influence consumers *not* to elect Blue Cross coverage. Yet respondents have never challenged such *adverse* treatment of Blue Cross, and proceed here as if such different treatment did not exist. As commercial insurers and health maintenance organizations, respondents seek to enjoy all of the benefits of different state regulatory approaches to different insurers, and none of the burdens. Their complaint thus reduces to a result-oriented theory that state efforts which take account of various burdens imposed on Blue Cross are preempted, even though imposition of the burdens in the first place was not. Nothing in ERISA provides support for that awkward proposition.[2]

POINT I

THE STATE IS ENTITLED TO TREAT DIFFERENT CATEGORIES OF PAYERS DIFFERENTLY.

The provision establishing lower in-hospital rates for Blue Cross patients is part of a comprehensive law regulating the provision of health care in New York. Just as New York law sets rates for some patients that reflect the need to facilitate access to hospital care for other patients (*e.g.*, charity and Medicaid patients), the law also provides that patients covered by commercial insurers and self-insured funds, among others, should pay at higher rates than patients of Blue Cross. There is nothing nefarious about this differential; it simply takes ac-

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[2] This Reply Brief on behalf of the Hospital Association of New York State will address only the "relates to" issue. HANYS relies on its discussion of the insurance savings clause in its initial brief. HANYS also relies upon and adopts the arguments on the savings clause contained in the co-petitioners' reply briefs. On the issue of the deemer clause, HANYS agrees with the position of the Petitioners Mario M. Cuomo, *et al.*, that the district court and the Second Circuit did not rule on that issue and, should the issue of the deemer clause need to be resolved, the case should be remanded so that it can be fully briefed.

count of the unique disadvantages under which Blue Cross plans have long operated, and the role Blue Cross has played in meeting the State's public policy objectives.

Respondents' contention that the 13% differential is nevertheless preempted, because it has a sufficient "connection with" ERISA plans, is now limited to the purpose and effect of the differential being to manipulate plan decisions. Resp. Br. 16. Respondents have completely abandoned the economic impact test relied upon by the Second Circuit Court of Appeals, (J.A. 52-55), and now seek a narrow opinion solely on the alternative "purposeful interference" basis for the Second Circuit's holding. Resp. Br. 26. Like the economic impact test, this "purpose" argument is not supportable.

A. The Playing Field

In attacking the New York law, respondents would have this Court start in the middle and assume that all providers of health care coverage are alike and must be treated alike. But this view bears little connection to real life. Commercial insurers, Blue Cross and HMOs operate in entirely different regulatory environments. As respondent HMO Conference points out, there is virtually no similarity between regulation of indemnity insurers and HMOs. The HMO Conference touts its lower premiums, but fails to cite to one of the main reasons; HMOs enjoy the *unique* benefit of being entitled to negotiate their own in-patient rates. N.Y. PUB. HEALTH LAW § 2807-c(2)(b)(i). *See* HANYS Br. nn.6 & 20. In that regard, therefore, it is the choice of Blue Cross over HMOs that is burdened with financial consequences.

Similarly, as between Blue Cross and commercial insurers, Blue Cross is uniquely subject to an extensive, complex regulatory scheme that generates costs that are

passed on in premiums. *See* HANYS Br. n.21.[3] Commercial insurers enjoy another benefit not enjoyed by Blue Cross plans or HMOs, a 2% discount for prompt payment to hospitals. N.Y. PUB. HEALTH LAW § 2807-c (11)(e). *See* HANYS Br. nn. 8 & 20. Each of these different regulatory treatments results in the choice of Blue Cross plans being burdened by financial consequences not experienced with the choice of commercial insurers or HMOs, allowing them to develop premium structures different than Blue Cross could. Commercial insurers, therefore, have enjoyed lower premiums (J.A. 168, ¶ 19), a fact that respondents have not disputed. This is the playing field, together with the costly burdens of open enrollment and community rating, that was being "leveled" by the 13% differential.[4]

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[3] These unique and costly obligations include approval of premiums by the Superintendent of Insurance after public hearing; regulatory controls on administrative expenses, reserves and surpluses; and limitations on other lines of business. *See generally* N.Y. INS. LAW, art. 43; J.A. 160, ¶ 4; J.A. 197, ¶¶ 20-21; J.A. 215-216, ¶ 6.

[4] It is interesting that respondents, who rest their entire "connection with" argument on the purpose and effect of the differential, have themselves disputed the very proposition upon which they now rely, that the 13% differential was intended to "level the playing field" (J.A. 273, ¶ 4):

> [T]he history of the differential is not as the State defendants and Intervenors would have it. They seek to portray the differential as a device designed by the Legislature to level the playing field between Blue Cross and the commercial insurance industry. The facts, however, are somewhat different.

Respondents' position in the District Court was actually the same as HANYS', that the differential, when originally established by statute, was intended to reduce the difference in rates paid by all charge payers, including commercial insurers, and Blue Cross plans. J.A. 243-245, 275-276. In fact, the Record bears only one reference to a purpose of the 13% differential being to level the playing field (J.A. 165-166, ¶ 15).

Moreover, as to respondents' present claim about the 13% differential being targeted at commercial insurers and ERISA plans,

The regulatory structure to which Blue Cross plans are singularly subjected imposes "financial penalties," under respondents' reasoning (Resp. Br. 16), for choosing to insure through Blue Cross. Yet none of these "penalties" is being challenged by respondents, even though they have the exact same effect as the differential; they affect costs and therefore become a consideration in a plan's decisions regarding coverage.[5] Unless all Blue Cross plans, commercial insurers, HMOs and self-insured funds are to be regulated identically, a proposition none of respondents advance, incentives and disincentives will remain in the system. The fact that ERISA plans weigh these considerations can hardly be the basis for preemption. And the hope that the differential would serve to reduce the competitive disadvantages experienced by Blue Cross plans does not equate to a purpose of manipulating the selection by plans of coverage arrangements in order to force ERISA plans not to self-insure or to move from com-

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respondents previously argued that the codification of the differential "was targeted at all payors, including uninsured individuals, not just insurance companies." J.A. 276, ¶ 14.

[5] Under respondents' analyses, there can be no law more subject to preemption than the right singularly granted to HMOs to negotiate their own payment rates to hospitals. The differential pales in comparison to the economic advantage gained by negotiation of one's own rates. This is aptly demonstrated by the HMO Conference's Brief which emphasizes the lower costs to consumers who choose HMO coverage over Blue Cross or commercial insurers. Understandably, the HMOs do not challenge this "interference" in plan decisions, but there is no legal justification for failing to do so if one accepts respondents' arguments. While one might normally wonder why this "preference" for HMOs is not challenged by commercial insurers, the answer is obvious; commercial insurers are rapidly setting up their own HMOs to take advantage of this very disparity in treatment. *See* J.A. 128, ¶ 15; J.A. 125, ¶ 7; J.A. 130, ¶ 5. Commercial insurers, therefore, are not "the disfavored benefit payors" and Blue Cross plans the favored payors. Resp. Br. 16-17. Commercial insurers are "disfavored" in one facet of state regulation; Blue Cross plans are the disfavored insurers in so many other ways.

mercial insurers. By supporting the continued viability of Blue Cross plans, the State has not restricted, it has expanded options for all consumers, including ERISA plans.

B. Influence v. Mandate

Respondents' suggestion that there is no legal difference between the State's merely affecting costs which might influence a plan's decision and actually mandating that decision is incorrect. Resp. Br. 24. If it were correct, and merely influencing choice by affecting cost would suffice for preemption, then the "parade of horribles" (Resp. Br. 25) is a reality. A 1% surcharge would have the same legal effect as the 1000% surcharge posited by respondents. This Court, however, has never held that the mere fact that the impact of state law may influence a plan choice triggers preemption. Resp. Br. 18. This Court has held that where the state law removes plan choice, it is preempted. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

There is no limit to the number of state laws that will generate costs that may influence plan decisions, and, therefore, a law's having the effect of influencing a plan decision simply cannot logically be the test for preemption. It is when the influence becomes not just a factor, but effectively mandates that choice that preemption may be triggered. For example, it would be implausible to think that Massachusetts could not use various incentives to encourage insurance policies to cover mental health benefits (Resp. Br. 24)—such as by putting ceilings on the rates charged for such services—even though it is not free to mandate them. Indeed, those types of incentives are prevalent throughout the DRG system, a fact that respondents accept.[6] Although it may be that, at some

[6] By establishing prices, or rates, for different in-patient procedures, the State by definition, using respondents' phraseology,

point, laws regulating costs may so tilt the balance that they leave plans and other consumers little practical choice, that is hardly the case here. A 13% differential applied to one of many services covered by health insurance simply does not rise to that level.

It is not surprising, therefore, that the Record in this case contains no evidence at all that any plan's choice of coverage was mandated by the 13% differential. In fact, there is not a scintilla of evidence in the Record that any benefit levels have been reduced because of the 13% differential, or that a decision was made not to offer a benefit because of the 13% differential. The Record is not only devoid of support for respondents' overstatements about controlling and mandating plan coverage decisions (*see, e.g.*, Resp. Br. 25), but the only evidence in the Record is directly to the contrary, that ERISA plans change from Blue Cross *to the Travelers* for "superior performance" (J.A. 268, 270-71) and because of lower premiums. J.A. 168, ¶ 19.[7] By virtue of the interplay of subsections (a)-(c) of N.Y. PUB. HEALTH LAW § 2807-c(1), the State has afforded all consumers, including ERISA plans, more choice, and as discussed in our initial brief (HANYS Br. 34-35), affording plans the

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steps in and artificially alters the cost of hospital services that would otherwise exist in the free market. State-regulated rates will always reflect some state biases, such as for out-patient over in-patient procedures, and for reduced lengths of stay.

[7] One hearsay statement is made on behalf of respondents that certain plans may have changed their form of coverage in response to the 11% surcharge. J.A. 134, ¶ 14. No such statement is made anywhere about the 13% differential, in any of the 17 affidavits submitted on respondents' behalves (J.A. 115-145, 267-289, 298-300, 321-325, 336-340). This is apparently one reason why respondents attempt to blur the differences between these very different statutory enactments. These differences were not only recognized by the Second Circuit Court of Appeals (A-41), but even by respondents, The Travelers *et al.*, (J.A. 287, ¶ 3, Resp. Br. 3) and the HMO Conference (HMO Br. 7, 14, 16, 25).

same choices as all other consumers would be an illogical ground upon which to find preemption.

Lastly, Congress could not have intended the line for ERISA preemption to be drawn at the point where state laws may influence plan decisions, since the bounds of preemption would be no less broad than if economic impact alone were the test.[8] The contention advanced by respondents is that a law whose economic impact upon plans will differ based upon the choice of coverage necessarily becomes a factor in the plan's coverage decision. This is the influence, they say, that triggers preemption. But as explained in the briefs of petitioners and their amici, such expansive preemption would invalidate laws that could not have been within the intended scope of preemption.

For example, when New York State in 1988 completely revamped its hospital quality assurance regulations, contained in Title 10 New York Code of Rules and Regulations, the cost alone of the graduate medical education component of the regulations for just the first year was $122 million. J.A. 186, ¶ 32. These costs were then added into hospital rates and distributed among all payers, except Medicare. The impact of the new Part 405 regulations is no less than that of the differential and may not only influence plan decisions on the level of benefits to be offered, it may also influence coverage decisions. Self-insured plans, rather than paying the full increase themselves, may elect to insure through commercial insurers

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[8] While respondents The Travelers *et al.*, have abandoned the economic impact argument, respondents HMO Conference *et al.*, continue to argue the economic impact test advanced by the Second Circuit (*see, e.g.*, HMO Br. 29), as do their Amici. *See, e.g.*, GHAA Br. 5. Amici Trustees of and the Pension, Hospitalization Benefit Plan, *et al.*, not only argue for the economic impact test, but ask this Court to assure that the state's funding mechanism for bad debt and charity care also be held to be preempted. Amicus Federation of American Health Systems is arguing for a free market system. FAHS Br. 2, 3.

because of a lesser impact of the rate increase on premiums. If a regulation is preempted because it will cause plans to expend greater plan assets or reduce benefit levels, or consider changing coverage, then the entire Part 405 quality assurance regulations are preempted. Congress could not have intended the field of employee benefits to extend so far.

C. Congressional Intent

Contrary to respondents' contention (Resp. Br. 12, n.6), congressional intent is still the ultimate touchstone of the preemption analysis, whether the preemption be express or implied. *Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992). Even with an express preemption provision, congressional intent must be distilled from more than the statute's language where such language is not narrow and precise (*Id.*) Apart from the presumption against preemption of the state's police powers (*Cipollone, supra* at 2618), ERISA's own legislative history offers no indication that Congress intended to broaden the field of employee benefits to cover generally applicable laws (i.e., hospital rate-setting activity) that were not commonly thought of as part of the employee benefit field, and whose only impact upon plans is indirect and economic.[9]

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[9] Addressing Representative Dent's statement that ERISA's preemption provision was patterned after the preemption approach in the Health Maintenance Organization Act of 1973, respondents recite a subsequent observation of Representative Dent that ERISA preempts essentially any act of the state which would affect any employee benefit plan. *See* Resp. Br. 30, n.15. The thrust of that statement, however, was not to show that any law that *affects* a plan is preempted, which has never been the test, but that ERISA preemption can operate against any form of state act that can be viewed as under the color of state law. In fact, in the Senate floor debates, Senator Taft cited Representative Dent's remarks for that "color of state law" point when he asked Senator Javits whether state bar association rules could be subject to ERISA preemption. *3 Legislative History of the Employee Retirement Income Security Act of 1974*, 4789, HANYS Br. 22.

Rather, Congress's very substantial and specific activity in the Medicare and Medicaid fields advocating for and approving of states' rate-setting laws that encompass all payers, and in particular systems in which all payers do not pay the same rates, reflect that the field to be pre-empted did not include all-payor rate-setting systems like New York's. HANYS Br. 29-33. Petitioners are not seeking to "carve-out" a general exception for health care; the point is that this law is simply not preempted because it is not "connected with" ERISA plans as was envisioned by Congress when it made the federal government the exclusive authority over the field of employee benefits.[10] Congressional intent in health care would be thwarted if ERISA preempted rate-setting laws that treat ERISA plans neutrally, and whose only impact is indirect and economic, and which does not remove plans' freedom of choice. Respondents have studiously avoided addressing this point.

Nor is the goal of national uniformity advanced, since unlike the field of employee benefits, health care regulation, rate-setting and cost control, as well as insurance regulation, are and have always been matters purely of local concern and interest. Hospital regulation, hospital costs, and insurance regulation, including different treatment of Blue Cross plans, commercial insurers and HMOs, are inherently local, police power exercises, and the manner in which those police powers are exercised differs within every state. (*See, e.g.*, J.A. 189-192, J.A. 256-257; *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 240-41, n.6 (1979)). Respondents' distinction between free market and "state-created" disuniformities (Resp. Br. 23) is therefore unavailing;

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[10] Respondents reference to *Agsalud v. Standard Oil Co.*, 454 U.S. 801 (1981) (Resp. Br. 31) is irrelevant. *Agsalud* involved a statute that was clearly preempted because it directly and expressly regulated employers and the types of benefits they provide. Congress's subsequent exemption of the Hawaii statute is not informative as to the reach of ERISA preemption.

there is no free market in hospital care or insurance. As stated above, respondents do not contend that regulation of all insurance entities has to be uniform within a state or among states. If it is not uniform, there will always be advantages and disadvantages, incentives and disincentives built into the systems. National uniformity would not be furthered by elimination of the 13% differential.[11]

POINT II

THERE IS NO REFERENCE TO ERISA PLANS.

Respondents also submit that ERISA preempts the 13% differential because the provisions comprising the differential "refer to self-insured plans," (Resp. Br. 27-28), instead of using the term "all third-party payers." *See* N.Y. PUB. HEALTH LAW § 2807-c(1)(b). This argument was summarily dismissed by both courts below (Pet. App. A-22, A-71), and is unavailing here.

Public Health Law sections 2807-c(1)(a), (b) and (c) set rates for everyone by listing all categories of patients covered by the statute, including "self-insured funds".[12] There is simply no legal significance to listing

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[11] National uniformity fails as a basis for preemption for the additional reason that insured plans pay premiums, not hospital rates. Eliminating the differential will not eliminate differences in premiums, which are based upon numerous factors and costs individual to the insurer; it would just rearrange them. Since Blue Cross premiums are generally higher than commercial insurance premiums, elimination of the differential will, if anything, increase the disparity in premiums. Congress certainly could not have intended ERISA to mandate uniformity of premiums of all payers in every state.

The point is the same for self-insured plans, which do pay hospital rates. Unless Congress intended to require that hospital rates and Blue Cross premiums be identical, which is impossible, there will always be these differences and incentives, with or without the differential.

[12] The terms "self-insured fund" and "ERISA plan" simply are not synonymous. First, not all ERISA plans are self-insured funds.

the payers covered by section 2807-c(1)(b), as opposed merely to referring to "all other payers." It would be virtually impossible to regulate health care, particularly in the context of an all-payor reimbursement system, without the use of some term or phrase that may cover ERISA plans. Finding "reference" under such circumstances is inconsistent with the common sense approach of determining whether a state law relates to an ERISA plan (*Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)), since such an interpretation of that term will, almost inevitably, pose a threat of preemption to every state all-payor rate system, which respondents concede Congress did not intend. In the context of state regulation of health care costs and reimbursement, common sense requires that a statute has to do more than *encompass* ERISA plans for it to be held to *refer* to ERISA plans.[18] Respondents' position is also inconsistent

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A large percentage of ERISA plans, as respondents emphasize, purchase commercial insurance, Blue Cross or HMO coverage. The "reference to" argument would not even apply to those plans, since they are not encompassed within self-insured funds. Similarly, not all self-insured funds are ERISA plans. A governmental plan, for instance, self-insures but is not governed by ERISA. See ERISA § 4(b)(1), 29 U.S.C. § 1003(b)(1). The term "self-insured funds" also encompasses a range of entities that have nothing to do with any type of employee benefit plan, such as trade association funds. The point is that the statute does not make a reference to ERISA plans themselves; it just makes a reference to the categories of payers which may be used by a plan.

[18] Indeed, as the Third Circuit observed in *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1192, n.6 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), ERISA does not even preempt a state law that refers directly to the term "ERISA plan" where that reference can be excised without altering the legal effect of a statute in any way, such as a statute that prohibits race discrimination "including by an ERISA plan." Similarly, under respondents' reasoning, if the generally-applicable garnishment statute that was upheld in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), had listed every type of fund (including ERISA welfare funds) that could

with the fact that they accept the validity of the State's "even-handed" DRG methodology (*See* Resp. Br. 27), which also necessarily encompasses self-insured funds.[14]

CONCLUSION

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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have been subject to the state's garnishment procedure, it would have been preempted, even though its meaning would have been identical to the actual statute at issue in that case.

[14] Respondents' reliance on *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580 (1992) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) is therefore misplaced. In those cases, the laws at issue specifically addressed employee benefit plans, requiring them to structure their benefits in a certain manner. Because they were targeted at, and indeed, "premised on the existence of," employee benefit plans, (*see Ingersoll-Rand v. McClendon*, 498 U.S. 133, 140 (1990)), they "referred to" such plans. Those laws were thus vastly different from the generally-applicable law at issue here, which includes the term "self-insured funds" merely as a means of rounding out a complete list of payers, and not as a means of targeting either those funds, or ERISA plans, which may or may not be self-insured funds.